ANNEXURE V

# F M C NETWORK UAE

P. O. BOX: 50430, DUBAI, Tel – 04 3871900, Fax – 04 3977842
Email – approval@fmchealthcare.ae Helpline Number: 600-565691

WE TAKE CARE OF YOU

## Medical Expenses Claim form

Date: 11-Aug-2025
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1982-9671195-9
Card Holder's Name: AHMAD BILAL MUMTAZ AHMAD Age: 43Y - 7M - 0D Sex: Male
Card Holder's Tel No: Mobile No: 0529225259
Ins Card No: I019-010-118066908-01 Valid Upto: 5/5/2026
Company Name: FMC Standard Network Employee No: _____ Nationality: Pakistani

Clinical Details: Temp 36.8 B.P. 150 Pulse. 72
Signs & Symptoms: risk for fall
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follov
Diagnosis: E78.49 - Other hyperlipidemia, R11.2 - Nausea with vomiting, unspecified, R51.9 - Headache, unspecified, E86.0 - D

Management plan (Services inside the clinic including injections and investigations)

82465, ASSAY BLD/SERUM CHOLESTEROL , Lab,0005-149902-1021, CLOFEN -(DICLOFENAC SODIUM : 75 MG/3ML) SOLUTION INJECTION , Pharmacy,0005-150403-1021, PREMOSAN -(METOCLOPRAMIDE : 10 MG/2ML) SOLUTION FOR INJECTION , Pharm 207801-1002, LACTATED RINGER'S & DEXTROSE USP (CALCIUM CHLORIDE : N/A) (DEXTROSE : N/A) (POTASSIUM CHLORIDE : N CHLORIDE : N/A) (SODIUM LACTATE : N/A) SOLUTION FOR INFUSION SOLUTION FO NFUSION (500ML, BOTT THER/PROPH/DIAG INJ SC/IM , Co.Pay,96360, HYDRATION IV INFUSION INIT , Co.Pay,9, Consultation Gp , Gen

راني باديبورايل ثارا
Dr. Keerthana Rani Padip
General Practi
License No.: 37864
يتيكير الطبي ذم م
CITICARE MEDICAL C

Doctor's Name: KEERTHANA signature with seal:

Diagnostic Procedures referred outside:

I hereby authorize the physician, Hospital or pharmacy to file a claim for medical services on my behalf and I confirm that the mentioned examination/Investigation/therapy is given to me by the doctor. I hereby authorize any Clinic, Physician, Pharmacy person who has provided medical services to me to furnish any and all information with regard to any medical history, medica medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 11-Aug-2025

Pharmaceuticals (to be filled by treating doctor only)

| Medicine | Dose | Duration | Quantity |
|---|---|---|---|
| (NAPROXEN : 500 MG) TABLETS | TABLETS (20S, BLISTER PACK) | 3 | 6 |